Chapter 7
CRISIS CENTERS AND HOTLINES

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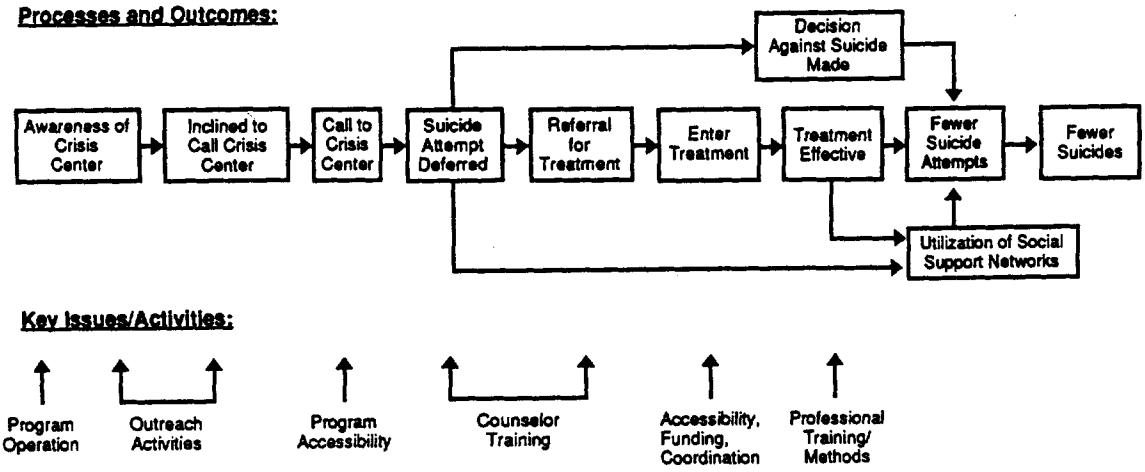
Overview and Rationale

The rationale for crisis hotlines (articulated by Litman, et al., 1965, and illustrated in Figure 7), relies on the premise that suicide attempts are often precipitated by a critical stressful event, are often impulsive, and are usually contemplated with substantial ambivalence (Shaffer, et al., 1988). Hotlines are designed to respond to the crisis and to deter a caller from self-destructive acts until the immediate crisis has passed. Crisis center hotlines offer an immediately available source of support; they do not require a trip to a clinic; and they are anonymous, allowing callers the opportunity to say anything in a context in which they may feel secure and in control.

Most crisis centers provide a telephone service that is available at least during the night (when traditional mental health services may not be available), and many operate 24 hours a day (Franklin, et al., 1989). These centers are typically staffed by volunteers. Some hotlines targeting adolescents are staffed by teen volunteers, but most hotlines serve clients of all ages, and volunteers are 18 years of age and older (Simmons, Comstock, and Franklin, 1989).

Many of the hotlines are part of a more comprehensive suicide prevention program, with strong linkages to schools and to mental health services. Many programs offer drop-in counseling services, whereas others offer only information and referrals, linking callers with existing community services.

FIGURE 7.
Rationale for Crisis Center and Hotline Programs to Prevent Youth Suicide



Research Findings

Evidence of the effectiveness of crisis centers and hotlines in preventing suicide is scarce and somewhat inconsistent. Results of an evaluation of changes in suicide rates in two British communities provided evidence of the effect of a hotline program (Bagley, 1968). Bagley compared suicide rates in a community following the introduction of a Samaritan suicide prevention program with the rates in a community with a 24-hour telephone crisis service staffed by clergy or laymen who referred callers to a psychiatric specialist. The study results showed a 5.8 percent decrease in the average suicide rate in the community with the Samaritan suicide prevention program and a 19.8 percent increase in the control community.

Results of studies in the United States (Bridge, et al., 1977; Weiner, 1969; Lester, 1974) have not duplicated this finding. Unfortunately, such ecologic studies (typically regression designs comparing cities with and without crisis hotlines) are not designed to measure program effects at the individual level—effects that, even if real and substantial, may not be evident at the community level.

In one study (Miller, et al., 1984), researchers found a small but statistically significant difference in the rate of suicide among white women 25 years of age and younger between communities with and without crisis center hotlines. Since young women are the most frequent users of hotlines, these results suggest that hotlines can have an effect on suicide rates among people willing to make use of their services.

Although there have been few evaluations of how hotlines affect behavior, there has been considerable research on hotlines, the results of which may help others develop effective hotlines (Auerbach and Kilmann, 1977; Dew, et al., 1987; Shaffer, et al., 1988; Stein and Lambert, 1984). Here are some conclusions of this research:

- **Hotlines reach an important audience.** Hotlines appear to serve an otherwise under-served population. Results of a survey of 3,000 college freshman (King, 1977) showed that only 8 percent of hotline callers were receiving other mental health services. In a study of a communitywide hotline in Los Angeles, researchers found that the census tracts from which calls were made corresponded closely to the census tracts with the highest rates of suicide (Lester, 1971). In a follow-up study in Cleveland, researchers found that callers to hotlines are indeed at higher risk of suicide than is the general population (Sawyer, Sudak, and Hall, 1972), although only 6 percent of those who committed suicide had been in contact with a crisis center. In a statistical "synthesis" of studies of crisis intervention, Dew, et al. (1987), found that crisis center hotlines were successful in attracting the kind of persons they wanted to attract.

- **Adolescents need to be made more aware of hotlines.** In studies of general hotlines, researchers have found that adolescents constitute only a small proportion of all callers (Litman, et al., 1965) and that adolescent suicide attempters may be significantly less aware of crisis services than adult attempters (Greer and Anderson, 1979).

  There is evidence that targeted advertising can increase awareness of hotlines among particular groups. For instance, following advertisement of the services of a crisis center among the high school population, 98 percent of high school students recognized the name of a specific crisis center, and during the next 3 years, 5.6 percent of them, mostly girls, made use of its services (Slem and Cotler, 1973).

- **Hotline service to young men needs to be improved.** Results of numerous studies have indicated that young women call hotlines more frequently than do young men (King,

1977; Morgan and King, 1975; Shaffer, et al., 1988; Slem and Cotler, 1973). Results of a survey of 3,000 college freshman to identify users of the hotline in a college community showed that young men who had used the hotline were significantly less satisfied with the service than were young women (King, 1977). This finding may have been a function of the type of problems involved in the calls. In another study (Getz, Fujita, and Allen, 1975), researchers found that callers with problems about parents felt more positively about the crisis intervention than callers who had serious mental health or drug problems. Both sexes reported greater satisfaction when their call had been taken by an opposite-sex operator.

- **Training is important.** Training appears to be important in determining the kinds of information and counseling provided by volunteer hotlines. Some researchers found that untrained volunteers were often overly directive, offering advice prematurely on the basis of inadequate information (Knowles, 1979; McCarthy and Berman, 1979). In another study, researchers found that untrained volunteers were less skilled than professionals in eliciting relevant past history and integrating caller information (Hirsch, 1981). Several researchers have found that training improved the quality of information provided and increased the frequency with which empathy and warmth were expressed in the telephone conversation (Bleach and Claiborn, 1974; France, 1975; Gentler, 1974; Kalafat, Boroto, and France, 1979). In one study, only volunteers who had received preliminary training improved with experience (Elkins and Cohen, 1982).

  These types of variables are related to the outcome of the calls. In one study of a hotline in Florida (Knickerbocker, 1972) in which researchers used independent ratings of tape-recorded calls, they found a moderate positive correlation between clinical effectiveness measures of empathy, warmth, and genuineness, and decreases in caller anxiety and depression from the beginning to the final segment of the call. (Caller segments were rated without the rater hearing the volunteer's voice.) Furthermore, in a study of a community hotline, researchers found that callers were more apt to show up at an appointment at a crisis center if the operator had given concrete directions during the initial hotline call (Slaikeu, Lester, and Tulkin, 1973; Tapp, Slaikeu, and Tulkin, 1974), or if callers rated the hotline counselor as showing greater understanding of the caller's problem (Slaikeu, Tulkin, and Speer, 1975).

- **Follow-through should be improved.** Follow-through of suggestions for action and receipt of counseling may be influenced by how much outreach the crisis center provides. Results of several studies suggest that compliance can be improved if the volunteer or clinician makes an actual appointment for the caller rather than simply providing the caller with a number to call. In one study, the compliance rate for attempters seen in an emergency room was 82 percent when an appointment was made versus 37 percent when only the name of a clinic was provided (Kogan, 1975). In another study, 55 percent of adults who called a hotline kept at least two subsequent appointments at a mental health treatment clinic when the initial appointment was made for them, compared to 37 percent of callers who were simply provided a name and phone number (Rogawski and Edmundson, 1971). Sudak, et al. (1977), reported compliance rates of 60 percent for a service in Cleveland where hotline operators routinely made clinic appointments (instead of relying on the caller's own initiative) and undertook further follow-up if an appointment was not kept.

  Training in referral procedures is important. For instance, the results of one study of typical calls to hotlines showed that 15 percent of callers were given inaccurate

information by counselors and that callers were frequently given a wide range of alternatives without the counselors' screening the one most appropriate for the callers (Bleach and Claiborn, 1974).

Illustrative Programs

In the United States, there are several hundred telephone hotlines and crisis centers (a listing of these centers is available from the American Association of Suicidology in Denver, Colorado). The programs described in this report have been included because of their time in operation, the extent of their outreach activities, and their linkages to local mental health centers and other youth suicide prevention programs.

Program	Rationale for Inclusion
Suicide Prevention Center Dayton, Ohio	• Eight years in operation • Comprehensive program
Youth Crisis Hotline Baltimore, Maryland	• Expanding to statewide hotline with local referrals
Crisis Center of Collin County Plano, Texas	• Eight years in operation • Linkages to school-based suicide prevention programs
Suicide Prevention and Crisis Call Center Reno, Nevada	• High-risk area served • Comprehensive program • Some evaluation efforts underway

Evaluation Needs

Crisis centers and hotlines may serve a variety of important functions, only one of which is the prevention of suicide. Nevertheless, suicide prevention is one of the key reasons why many crisis centers and hotlines are established, so it is important to determine how effective they are in this regard.

The question of whether crisis centers and hotlines prevent suicide can be subdivided into several questions:

- **Are the people who use crisis centers at high risk of suicide?** As noted, the demographics suggest that crisis centers and hotlines are used by young women, a group generally at relatively low risk of suicide. The young women who use the crisis centers and hotlines may, however, be at high risk.
- **Would people who use the crisis centers and hotlines commit suicide if these centers and hotlines were not available?** Perhaps people at high risk of suicide who use hotlines would seek care through mental health centers or other mental health resources in the community if hotlines were unavailable. It is therefore important to determine whether crisis centers and hotlines increase the referrals of people who might otherwise not use community mental health resources.

- **Do people who use crisis centers and hotlines commit suicide at a lower rate than otherwise similar people who cannot use hotlines (because this service is not available or is unknown to the suicide victim)?** Such questions might be answered by comparisons between locales with and without crisis centers or hotlines; studies of this design are, unfortunately, very challenging to conduct and interpret.

Two questions about intermediate objectives should also be addressed:

- **What encourages high-risk youth to use hotlines?** Obviously, hotlines can only be effective if they are used. Thus, we need to know what kinds of outreach activities are effective in getting high-risk youths, particularly young men, to use the hotlines.

  In this regard, it might help if hotlines around the country could periodically share information. Most hotlines keep track of the basic demographic characteristics of their callers (e.g., age category, sex, and nature of the call). If programs shared this information, hotlines that are serving a relatively high proportion of high-risk youth might be identified and the methods used by these hotlines to publicize their services could then be shared with other hotlines. At the individual program level, the demographics of callers could be monitored for changes resulting from intensified outreach or publicity efforts.

  Another way to assess the use of hotlines would be to conduct a community survey to assess people's knowledge of the hotline and factors that might influence their willingness to use it. If the survey is conducted as part of existing school-based or other community surveys, this information might be gathered at relatively little cost. Such surveys might provide information about knowledge of and perceptions about the hotline that could influence its use.

- **What makes hotlines effective in convincing callers to receive counseling?** Another important issue is how hotline programs influence the behavior of callers. The method of determining this will vary with the confidentiality procedures in place in different programs and situations.

  — *Follow-up of referrals.* Some, but not all, callers will be referred to a crisis center or a mental health clinic. In some situations, a caller will provide a name that can be used to check whether a follow-up visit was made. This will most likely be the case when callers are referred to the center or clinic that operates the hotline, thus enabling officials to determine whether a client kept an appointment without violating confidentiality procedures.

    In other programs, because callers are anonymous, follow-up by name is not possible. In such programs, data might be obtained by arranging for personnel in the treatment programs receiving referrals from the hotline to ask clients at first contact how they came to their agency. Treatment programs could then provide aggregate data on the number of new clients referred by the hotline.

  — *Follow-up of callers.* Not all callers will receive a referral to another setting. In many of these cases, callers will be asked to make a specific change or take a specific action. In these situations, studies might be conducted by asking the callers to call their counselors after a specified period to let them know how things are going.

Summary

Many programs have crisis centers or hotlines to help deal with suicidal people. These programs are based on the premise that youth suicide can be precipitated by a stress event and that suicidal feelings are almost always temporary and accompanied by ambivalence. Hotlines offer an opportunity to help deter self-destructive acts until the immediate crisis has passed and to help callers connect with mental health resources.

Although hotlines may provide a variety of important services to callers, their effectiveness at reducing the rate of completed suicide to the community has not been established. Researchers have found that the way volunteers handle calls can influence the mood of callers and the likelihood that callers will keep appointments for counseling. The results of one study indicated that hotlines may reduce the rate of suicide among young women. On the other hand, hotlines as now constituted tend to be used by populations at relatively low risk of suicide (young women). The effectiveness of hotlines on the rates of suicides among young men has not been demonstrated.

If the rationale for this approach is sound, the effectiveness of hotlines and crisis centers for youth suicide prevention might be improved by increasing outreach to young males, requiring consistent training of volunteer staff, and taking steps to improve follow-through with callers.

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Suggested Additional Reading

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Crisis Centers and Hotlines: Program Descriptions

Suicide Prevention Center Programs

Location: Dayton, Ohio
Contact: Linda Mates, LPCC, (513) 297-9096

Targets: Students (junior and senior high school), gatekeepers.
Years in operation: 25
Source of funding: United Way, the state, and community taxes.
Amount of funding (per year): $130,000.

Program description: The Suicide Prevention Center (SPC) provides a broad range of crisis support services, including a 24-hour crisis hotline, training of professionals (teachers, service providers, clergy, physicians, police, etc.), and a crisis response team for postvention work for individuals or groups. Specific programs are:

Child Puppet Program: Started 7 years ago, this program for younger children (grade school) helps them deal with the grief involved in the death of a loved one.

Lives In Transition: This program targets youth with physical disabilities (grades 4-6).

Besides identifying those most at risk, educating students and gatekeepers, and intervening with students after the death of a friend or family member, the SPC also works directly with students through intervention and follow-up. When necessary, adolescents may be hospitalized; child services and the police are consulted when youths are not in school.

Coverage: Countywide.

Evaluation: Several evaluations are ongoing—quality assurance, client satisfaction, and client outcome.

Data availability: Intervention, referral, and follow-up information is available. Data are being collected on calls to the hotline, and a mechanism is in place for following up referrals.

Related components:

- General suicide education
- Crisis center and hotline
- Gatekeeper training
- Parent programs
- Postvention

Address: Linda Mates, LPCC
Executive Director
Suicide Prevention Center, Inc.
PO Box 1393
Dayton, OH 45401

Reports: Program manuals and evaluation materials, pamphlets.

Advice to others interested in starting this type of program:

- Research your community
- Build coalitions
- Train adults first

Youth Crisis Hotline

Location: Based in Baltimore but serves state of Maryland
Contact: Henry Westray, Jr., M.S.S., L.C.S.W., (301) 225-5060

Targets: Youth (ages 15-24).
Years in operation: The program has been fully operational for 2 years. The Governor's Task Force on Youth Suicide Prevention convened in 1985 for 1 year. Since October 1989, all school districts have received funding for Youth Suicide Prevention programs.

Source of funding: Money for the Task Force, the Maryland Department of Education's Youth Suicide Prevention School Program, an annual statewide conference, the Youth Crisis Hotline, and the program coordinator's salary was provided by the state. Additional resources were provided by Marylanders Against Youth Suicide (MAYS), various corporations, and a local television station.

Amount of funding (per year):

- Task force (1985 to 1986 only) — $60,000
- State coordinator's salary — $40,000
- Youth crisis hotlines — $150,000
- Maryland Department of Education (school programs and annual conference) — $161,000
- Marylanders Against Youth Suicide (MAYS) — $5,000
- Corporations and a local T.V. station (1990–1991 only) — $80,000

Program description: A new statewide hotline was implemented in August 1990. After calling an 800 number, callers are directed to the nearest of six centers. Each center issues monthly reports on the types of calls received and quarterly reports based on this information.

While the program is included in this section because of the statewide coverage of its hotline, one of the distinguishing features of the program is its involvement with a number of youth suicide prevention activities. These include formation of a task force that collected information on youth suicide prevention efforts across the state. All counties in Maryland and Baltimore City provide prevention programs for youth, parents, schools, and communities. There are youth peer leadership groups in which youth leaders are trained to assist troubled peers and make appropriate referrals. All young people receive training from the Department of Education and local prevention coordinators.

The Student Assistance Program (SAP) is in place in public schools to identify troubled youths and refer them to appropriate services. Suicide prevention education is a major component of the mandatory training for all SAP members, who are adult professionals within the school.

Colleges and universities across the state were invited to share their policies and procedures for dealing with students in emotional crisis or who are suicidal and to provide information about campus programs targeted to youth suicide prevention, intervention, or postvention. Most colleges and universities reported that they have no written suicide prevention policies, but most had a written policy for dealing with students who reported being suicidal.

The state coordinator and the Governor's Interagency Workgroup for Youth Suicide Prevention direct and oversee youth suicide prevention activities in Maryland. The Interagency Workgroup and representatives from various county and city agencies, youth advocacy groups, and other organizations have formed four committees that focus on major areas related to youth suicide. These committees are the Community Information and Resources Committee, the "At-Risk" Populations Committee, the Grant Proposal and Research Committee, and the Cult Awareness Committee.

Outreach: With the exception of the Grant Proposal and Research Committee, each committee has conducted educational workshops around the state in order to educate professionals and the community.

- The "Lifeline, Youth Suicide Prevention Campaign" included a television special on youth suicide prevention and a year-long media campaign sponsored by the Maryland State Department of Health and Mental Hygiene, MAYS, Pizza Hut, and Fox 45 Television Station. This campaign began September 1990.
- A second media campaign was begun August 1990 in cooperation with the start-up of the Youth Crisis Hotline. Included was a "kick off" and a reception, which featured the governor of Maryland, who proclaimed August 8 as Youth Crisis Hotline Day in Maryland. Press packets were sent to the media.
- The governor proclaimed October to be Youth Suicide Prevention Month. Press packets were sent to local media outlining statewide events during this month. Two of the major events during this month were a statewide Conference on Youth Suicide Prevention and a "Kick-Off" program to start a calendar of events throughout the state.
- Numerous television and radio stations, as well as the print media, featured the Youth Crisis Hotline and Youth Suicide Prevention activities in Maryland. The State Department of Health and Mental Hygiene distributed flyers, t-shirts, and over 700,000 stickers and wallet-sized cards featuring the numbers of hotlines across the state.
- The Maryland State Department of Health and Mental Hygiene and MAYS coordinated training for various groups and organizations across the state.

Coverage: Statewide.

Evaluation: Annual programmatic and statistical review by the state.

Data availability: Governor's Task Force Report on Youth Suicide in Maryland. Selected data are collected on the youth crisis hotline. Evaluations were completed by participants of youth suicide prevention conferences held in 1989 and in 1990.

In January 1990, a statewide survey was sent to all county commissioners and executives in order to determine the prevention activities in their jurisdictions. An attempt was also made to sensitize this group to the problem of youth suicides.

In November 1990, a survey was sent to selected schools, police departments, and child care agencies across the state in order to investigate suicide and cult-related activities.

Special population outreach: Several workshops have been done to educate professionals and others concerning the problems of gay youth. The state has been working closely with various gay organizations in this regard. The "At-Risk" Populations Committee has prepared a training module related to gay youth.

African-American Suicide. Maryland's 1990 Youth Suicide Prevention Conference included a workshop titled "African-American Suicide." The state has worked collaboratively with the Baltimore City Health Department, Baltimore City schools, and other organizations in order to focus on this increasing problem.

Related components: Youth Crisis Hotline Centers have established linkages with and referred callers to local mental health centers and to other needed community resources across the state.

Address: Henry Westray, Jr.
Coordinator for Youth Suicide Prevention
201 West Preston Street
Baltimore, MD 21201

Reports:

- Task Force Report, 1987.
- Task Force Report, 1990 Update.
- "Developing Community Resources" — Report on the Second Annual State Conference on Youth Suicide Prevention, October 9, 1990.
- Brochures and other items about and distributed by individuals and organizations involved with hotline activities.

Crisis Center of Collin County

Location: Plano, Texas
Contact: Barbara Blanton, M.S.N., R.N., (214) 881-0088

Targets: All ages (no separate teen line).
Years in operation: 8
Source of funding: Grants, fund raising, donations, some city and county funding.
Amount of funding (per year): $156,000.

Program description: This is a 24-hour telephone hotline service staffed mostly by volunteers who have been trained in suicide prevention techniques. Established in 1984, it is certified by the American Association of Suicidology. A telephone log of all calls is maintained, and each call lasting more than 5 minutes is extensively documented. There is no separate teen line, but volunteers do request the name of the school from all young callers.

In special circumstances, follow-up on hotline calls is conducted. Calls from students who seem to be at risk of injuring themselves or others are pursued by contacting the appropriate school counselor. Hotline volunteers also network to provide emergency help for all at-risk persons. As part of the suicide prevention program in the schools, they notify school counselors of all at-risk students; they do the same in the postvention program.

Outreach: Wallet cards are handed out to students as part of the general suicide education component. Informational brochures, stickers, and posters are distributed community-wide. A Survivors of Suicide support group meets three times a month. Community education of adults is also a high priority.

Coverage: Countywide.

Referral procedures: Referrals are made to local mental health facilities and other community agencies. Staff members also receive referrals from teachers and students, especially after education presentations.

Evaluation: No specific evaluation of the hotline services has been conducted; however, the services have always gotten positive verbal feedback. A letter is being sent to all agencies to which clients are referred asking for feedback. To assess the impact of the program, hotline counselors collect survey data from callers when appropriate. School-based programs are evaluated through forms to teachers, counselors, and volunteer presenters. Pre- and posttests are given to students to evaluate knowledge and presentation.

Data available: Telephone logs are used to collect data on demographic characteristics, on referrals, on the type of or reason for the call, and on whether it is a repeat call. Volunteers are often unable to get the name and location of callers, which makes follow-up difficult.

Special population outreach: Outreach efforts are targeted at persons of all ages: teachers, counselors, school administrators, businesspersons, persons in senior citizen centers, suicide survivors, physicians, and funeral home directors.

Related components:

- School gatekeeper training (high school and college)
- Community gatekeeper training
- General suicide education (youth, college students, adults)
- Postvention after a suicide, homicide, unintentional injury/death, or molestation by a teacher
- Survivors' groups

Address: Barbara Blanton, M.S.N., R.N.
Executive Director
Crisis Center of Collin County
PO Box 861808
Plano, TX 75086

Reports:

- Program description (brochures)
- High school curriculum
- Middle school curriculum
- Evaluation forms

Advice to others interested in starting this type of program: Begin with a survey of available services and gaps in services. Coordinate with existing programs, especially the local community mental health center. Community support must be established prior to offering services. Gather input from as many sources as possible (e.g., schools, hospitals, community agencies, community leaders, local government, and private practitioners).

Suicide Prevention and Crisis Call Center (SPCCC)

Location: Reno, Nevada
Contact: Roger Simon, Executive Director, (702) 323-4533

Targets: Teens, school personnel, parents.
Years in operation: The SPCCC has been in operation for 24 years.
The Youth Program has been in operation for 4 years.
Source of funding: United Way, grants, and service-in-kind with University of Nevada-Reno. The Youth Program receives additional funding through community block grants and the E. L. Cord Foundation.
Amount of funding (per year): The SPCCC has a budget of $145,000 and the Youth Program has an additional $15,000.

Program description: The Suicide Prevention and Crisis Call Center offers a 24-hour crisis line, a youth suicide prevention program, a support group called Survivors of Suicide, elderly outreach, a 24-hour child abuse and neglect hotline, a child abuse and neglect prevention program, and a face-to-face rape crisis intervention program. The hotline is part of a comprehensive program offering training and education to school staff, students, and parents on teen suicide and its prevention. The hotline provides information on suicide, emotional support, crisis intervention, and referral for all callers, regardless of the type of problem. The program is especially important, since Nevada has the highest suicide rate in the United States.

Outreach: The elderly, teens, rape victims, and the general population.

Coverage: Statewide. (The center has an instate toll-free number.)

Evaluation: The center is conducting a community survey on the entire Crisis Call program, especially the hotline. The survey is being done in conjunction with a student from the University of Nevada-Reno as part of his thesis. No follow-up evaluation is planned because of Washoe County School District regulations.

Findings: None yet.

Data available: Several studies on suicide in Nevada have been conducted, including one by CDC. Analyses include rates by age, race, and sex; questionnaire data on calls to the Crisis Call line; and the results of surveys in different high schools conducted before and after training programs. Data from the hotline include the caller's age, sex, and reason for calling.

Special population outreach: Rural and low-income populations are a focus for all SPCCC programs.

Related components:

- General suicide education
- Parent programs
- School gatekeeper training
- Survivors' groups

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Reports: The program description and results of surveys are available.

Advice to others interested in starting this type of program: For a teen program, a good working relationship with the local school district is essential to developing a rapport with the schools. Our rapport is with the Office of Student Services. Start by making presentations to school staff and then getting permission to educate students. Emphasize that this type of prevention program has been proven to *reduce* the risk of teen suicide in a community. (The fear tends to be that talking about suicide in the schools will increase the number of attempts.) In Washoe County (where Reno is located), the number of teen suicides has dropped by half since 1986 when the program was implemented, even though the total number of suicides in the county has continued to rise.